ANNUAL REPORT -- 1996

OPTIONS FOR FAMILY CARE

a contract funded by the U S Agency for International Development, implemented by John Snow, Inc

ANNUAL PERFORMANCE REPORT

Project:	Options for Family Care
Contractor	John Snow, Inc
Contract #.	279-0090-C-00-5516
Reporting Period	January 1, 1996 to December 31, 1996
Report #·	Q-08/A-02

Section I - CONTRACTOR'S REPORT

A. Narrative:

1 Background

This report summarizes activities and accomplishments under Contract No 279-0090-C-00-5516 between USAID and John Snow, Inc during the calendar year 1996

The Goal and Purpose of the USAID Options for Family Care Project (OFC) are

Goal "To improve Yemeni family health and welfare", and

Purpose "To increase use by Yemeni women and children of health services in target governorates"

Under this Project, USAID executed a contract with John Snow, Inc (JSI) on January 10, 1995 In the months following contract execution, JSI and USAID/Yemen discussed and planned for a variety of changes to the contract scope of work which would have focussed efforts more directly on a number of specific MCH/FP service delivery problems, expanded the geographic scope of the project to include a total of four governorates, and lengthened the time frame of the contract from three to five years This anticipated contract amendment was dependent on USAID/Yemen's revision of its own Strategic Framework This revision did not occur as planned, and the contract was therefore not amended in 1995 as anticipated Nonetheless, the JSI team planned and began to implement contract activities based on agreement with USAID/Yemen concerning the likely nature of the anticipated Contract amendment The Contract Master Plan and the 1996 Annual Workplan -- developed in close collaboration with Ministry of Public Health (MOPH) colleagues -- reflect this agreement, and served to guide Contract implementation through the first half of 1996

As USAID/Yemen continued without success to redefine its Strategic Framework,

USAID globally began to experience the most serious funding crisis in its history Draconian cuts were made in project and operating expense budgets, many USAID Missions around the world were closed, and plans were made to close additional Missions In April, 1996, USAID announced its plans to close the Mission in Yemen on September 30, 1996 It was not clear during the months between April and September whether or not the JSI Contract would be continued or terminated

In July and August, 1996, USAID/Yemen staff collaborated with their colleagues from USAID/Washington and USAID/Cairo in finalizing plans for the continuation of USAID-funded activities after Mission closure on September 30, 1996 Agreement was reached with JSI on a scope of work, workplan, and performance indicators for an amended contract which would extend through September 30, 1998 This agreement was most welcome, since the uncertainty surrounding both the exact nature of the contract -- dating back to March, 1995 -- and whether or not the contract would be terminated -- dating back to April, 1996 -- had limited JSI's ability to effectively implement a program of assistance While the staff made every effort to move forward on those activities for which there was agreement with USAID/Yemen, many critical steps could not be taken for fear that JSI would be mobilizing Yemeni colleagues and communities for activities that could not ultimately be implemented

The contract amendment was finalized in October, 1996 in coordination with the Regional Contracting Officer from USAID/Cairo The scope of work is summarized by a new "Health Sector Special Objective" which defines the Special Objective, Intermediate Result, and Lower Level Results for the contract Albeit narrower and of shorter duration, this scope of work is largely consistent with the work that the JSI team had been implementing over the first eighteen months of the contract

This report is prepared in accordance with the standard reporting format issued by USAID

2 Expected Results

The **Special Objective** is

"Improved quality and use of integrated MCH/FP services in 22 Health Centers in three governorates"

The **Intermediate Result** is

"'Health Center Improvement' model in 22 Health Centers in three governorates established and documented"

The three **Lower Level Results** are

1 "Sustainable female staffing established in centers in three governorates"

2 "Minimum quality standards for centers in place in four[1] governorates"

3 Community and individual participation increased in three governorates"

This report contains details of activities undertaken to achieve the Special Objective, Results, and the associated targets

3 Core activities during this reporting period

Core activities during 1996 are grouped under the Lower Level Result to which the activities contribute

Lower Level Result 1 "Sustainable female staffing established in centers in three governorates"

> *Achievement of this Lower Level Result will mean that the number of female health care providers at target Health Centers will be increased through a decentralized training system that can better sustain the future training and support for those providers*

a Special support for training midwives in Hajjah governorate

While a lack of formally trained midwives is a major problem throughout Yemen, the shortage is more acute in some areas than in others Of the OFC-assisted governorates, Hajjah has the fewest number of midwives there were less than ten on the MOPH payroll in 1995 As a special effort to address this problem, JSI began providing salary support for two midwifery trainers at the Hajjah Health Manpower Institute (HMI) in 1995 During 1996, these trainers successfully completed the training of twelve new midwives, and began the training of an additional class which will graduate in June 1997 Two local midwives are being prepared to serve as trainers at the HMI in the future

b Participation in MOPH Midwifery Training Taskforce

JSI/OFC staff have actively participated in the MOPH's planning and implementation of a five-year national scheme for the training of

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[1] This Lower Level Result includes activities in Lahj Governorate, which are generally restricted to renovation and equipping of health centers, training of existing staff, and technical assistance to health centers (As detailed in the Contract Master Plan, Lahj was originally anticipated to receive all Contract inputs) Under the amended Contract, all activities in Lahj are to be completed by September 30, 1997

approximately 4000 new community midwives Many of the strategies developed by OFC have been incorporated into the Ministry's plan, including a decentralized approach to training at selected Health Centers throughout the country, recruitment of trainees based not only on educational qualifications but also on their expressed ability to complete the training and to work thereafter, and solicitation of community support for the training The preparation of these decentralized centers with strong community support represents the best hope for a sustained effort to meet the country's need for additional female MCH providers Items c-h below, as well as much of the discussion under Lower Level Result 3, describe specific OFC activities related to the training of new community midwives

c Identification of decentralized training centers

OFC-supported training of community midwives will take place both in branch (i e , governorate-level) HMIs in Hadramaut, Hajjah, and Hodeidah, and in selected health centers Criteria for selecting health centers have included the geographic distribution of the centers, the capability of the centers to take on responsibility for managing the training, the ability of the governorate Health Offices and HMIs to support the training, and the extent to which communities offer to financially and managerially support the training

Based on these factors, the following OFC-supported health centers were selected to serve as training centers

Hadramaut	1	Seyoun MCH Center[2] (located within Seyoun Hospital)
	2	The course at the HMI in Mukulla will serve Mukulla and Al Shaher Districts
Hajjah	Community Midwives will be trained at	
	1	Shagadirah MCH Center
	2	Mabyan MCH Center
	3	Ku'aydinah MCH Center
	4	Mahabisha MCH Center[3]

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2 Seyoun was added as a training site during the last quarter of 1996 Discussions among OFC, USAID, the central MOPH, the Hadramaut Health Office, and community leaders in and around Seyoun led to this decision, based on the great need for additional midwives there While substantial effort will be required to prepare the training site, recruit the trainees, and formalize the necessary community support, all parties agree that the work can be accomplished quickly and that the benefit justifies the effort

3 Mahabisha was added in the fourth quarter of 1996 in response to a special request from the Health Office and the community This training course will upgrade existing Female Primary Health Care Workers for certification as Community Midwives The course will thus be shorter in duration, can be undertaken at modest expense, and will provide the MOPH with a "test case" of upgrade training at a decentralized site

Female Primary Health Care Workers will be trained at

1 Bani Qais Health Center
2 Al Moharaq Health Center

(Note that neither of these communities have young women who meet the educational requirements to become Community Midwives See the earlier discussion of the general shortage of midwives in Hajjah Governorate)

Hodeidah
1 Al Marawa'a MCH Center
2 Bait Al Faqih MCH Center
3 Al Zohorah MCH

Lahj — Plans to conduct community midwife training in Lahj had to be abandoned as a result of funding cutbacks

d Renovation of training centers

All decentralized training centers are also OFC-supported health centers Thus, renovations have been undertaken with both service delivery and training needs in mind Community Midwife training centers have been given priority for renovation, since training will need to begin no later than April, 1997 This renovation work, tailored for the needs of each center, includes preparation of space for didactic training as well as upgrading of the MCH clinical areas for both training and service delivery purposes

Plans for the renovation of all training centers were finalized during the third quarter of 1996, and the necessary contracting was completed for six of the Community Midwife training centers by the end of 1996 Contracts for the remaining Community Midwife centers will be completed in early January, 1997 By the end of 1996, the actual renovation work at five centers in Hajjah and Hodeidah, and the work at the remaining centers will be completed in time for the beginning of training in early April

e Recruitment of trainees for training centers

The scheduling of renovation work at each training center, as well as OFC's committment of various other forms of assistance, has been contingent upon each community's agreement to support the training in a variety of ways, including the identification of young women to be trained (This process is described more fully in the discussion of Lower Level Result 3 below) During the last half of 1996, each community began to identify and bring forward candidates, based upon educational qualifications, desire to become health care workers, and assurances from the women and their families that they would complete the training and serve their communities thereafter The importance of this process is well-recognized by USAID and JSI, and is reflected by the inclusion of trainee identification as a performance indicator

for the project By the end of 1996, the target for this indicator (#1 2) had been surpassed, with the identification of 699 potential trainees

f Recruitment of trainers for training centers

Active recruitment of experienced trainers for the training centers was begun during the third quarter of 1996 By the middle of the fourth quarter, i e November 15, all trainers had been identified In the interests of sustainability and of making use of local capabilities, preference was given to Yemeni candidates who possess a midwifery certificate and training experience The final group of trainers, a total of 19, includes 18 Yemenis and one Sudanese

During the third quarter of 1996, while OFC was making plans to begin the training of Community Midwives in early 1997, the MOPH announced a plan to conduct a training of trainers (TOT) for all community midwife trainers While the concept of providing additional training for these trainers is sound, JSI/OFC faces serious time constraints for the implementation of the actual training of community midwives if that training is to be completed by the end of the OFC contract However, the MOPH position that Community Midwives could not be certified unless their trainers had completed the TOT or an equivlent course forced a decision to postpone the beginning of the Community Midwives until April 1, 1997 While this schedule is uncomfortably tight, it still will allow for the training to be completed by the end of the OFC contract

The TOT began at the HMI in Sana'a on December 15, 1996 In addition to the nineteen OFC-sponsored trainees, additional trainees selected to conduct training in other governorates (numbering approximately 34) also began attendace on that date The three-month course was designed and implemented under the technical direction of PRIME/INTRAH with funding from USAID (The course is coordinated by PRIME's Dr Yvonne Sidhom, formerly the JSI/OFC training advisor) In addition to supporting the attendance of the 19 trainees, JSI/OFC is also providing support for two trainers to assure an effective trainee-to-trainer ratio As of the end of 1996, the TOT was progressing satisfactorily, on target for a March 15, 1997 completion date

g Ordering of training equipment

Each of the training centers will require some basic training tools and equipment A list of this equipment and other materials was finalized and appropriate items were advertised for bid during the third quarter of 1996, and was delivered in Yemen in December The equipment includes slide and overhead projectors, TV/VCRs, anatomical models, and flip charts A basic library of training and reference materials will also be provided, with an emphasis on Arabic language references when available All of this material

is thus available for delivery to the training centers before the beginning of the training in April

h Renovation and other assistance to HMIs

In addition to the Community Midwife training at decentralized centers, OFC will also support training at the HMIs in Hadramaut, Hajjah, and Hodeidah OFC inputs to support this training are analagous to those being provided at the decentralized centers support for trainers and for trainees from OFC target districts, equipment and materials, and facilities renovation necessary for the conduct of the training The support for trainers and the provision of equipment proceeded in the same manner as discussed above for the decentralized centers The renovation work at the Hadramaut HMI was completed in December, and the work at the Hajjah HMI was in progress and on schedule Work at the Hodeidah HMI was delayed because of uncertainties about the capability of the HMI to successfully undertake the training JSI has made it clear to the HMI and to the Health Office that it will not commit substantial resources, such as the renovation, without assurances that the training can be implemented and completed Negotiations to obtain these assurances were ongoing through the end of 1996, involving JSI/OFC staff, the Hodeidah HMI and Health Office, and the central MOPH and HMI The Lahj HMI is also being provided with some renovation and equipment to fulfill part of the OFC committment made prior to the decision to limit assistance to that governorate

An additional motivation for providing this assistance for the governorate HMIs is that, under the MOPH plan for training community midwives, they are assigned the essential task of supervising the decentralized training is delegated to the governorate branches of the Health Manpower Institutes (HMIs) It will prove difficult for the HMIs to fulfill this responsibility, since the HMIs suffer from the funding shortages, human resource inadequacies, and management difficulties that are typical of Yemen Government social service institutions JSI/OFC assistance is therefore being used in part as a *quid pro quo* arrangement where OFC will provide support to the HMIs in "exchange" for the HMI's agreement to fund supervision Whether or not this arrangement has the desired result will be an interesting "lesson learned" from the project, and will therefore be monitored and documented

Lower Level Result 2 "Minimum quality standards for centers in place in four governorates"

Achievement of this Lower Level Result will mean that target Health Centers are enabled to deliver services of significantly higher quality through improvements in facilities, equipment, skills of staff, and clinical and management practices This should result in greater utilization of MCH/FP services

a Training of Trainers Workshop

In June 1996, a month-long workshop was held in Sana'a for the purpose of creating for each target governorate a team of local trainers capable of providing refresher training to the staff of health centers This activity therefore will serve to reduce reliance on expatriate trainers and training programs Twenty-four participants profited from the expertise of OFC staff serving as faculty, and all graduated successfully Part of the workshop curriculum was the development of refresher training plans for each governorate, the implementation of which are described below

b Refresher training for existing MCH service delivery staff

During the last two quarters of 1996, each of four governorate training teams (who were themselves trained as trainers by JSI/OFC in June 1996) began to conduct three rounds of refresher training for service delivery staff throughout the governorate (OFC staff ensured that the personnel from OFC target centers and associated units had priority in the training before admitting personnel from other centers) Three two-week session were conducted in each governorate for a total of 180 providers trained

The curricula for this training were developed by each governorate team, and the training was conducted by the teams with assistance from JSI/OFC staff and a few local experts Evaluations of the training were consistently high from both the trainee and trainer perspectives, and trainee performance was uniformly high as measured by pre- and post-tests JSI/OFC staff are following up the training during regular site visits to target centers, and are working with Health Office supervisory teams to incorporate follow-up into their supervisory activities A lack of regular site supervision by Health Office staff is a general problem, however

c Infection prevention training

In the first of a series of specialized clinical interventions, the JSI/OFC Clinical Advisor and Senior Nurse Midwife, together with the governorate-based Nurse-Midwives, attacked one of the most serious and common problems identified during the baseline assessments of target health centers Infection prevention practices are substandard at all centers, from basic cleaning of facilities to the clinical and personal hygiene practices of the staff Using a draft infection prevention protocol as a guide, JSI/OFC staff provided training at each target center designed to improve those practices The protocol is also being used in follow-up visits to monitor and continue to improve infection prevention

d HMIS development and training

The JSI/OFC Management Advisor provided key input to the MOPH MCH Division's development of a new, improved MCH/FP Health Management Information System The Management Advisor assisted MCH Division staff in determining whether and how each piece of data would be used in decision-making, and therefore whether or that data is really needed The result is a streamlined, common-sense system that should serve the MOPH well if it is properly implemented and used

To that end, JSI/OFC sponsored in July the training of teams from each governorate in the use of the system Faculty for the course were drawn from the MCH Division's statistics staff, and the trainees were drawn from each Health Office JSI/OFC staff from each governorate also attended as trainees so that they could assist in the training of center staff and follow-up of data collection/analysis

Following this "training of trainers", the governorate teams traveled to each Health Center that provides MCH/FP services, carrying with them the initial supply of the new registers, forms and cards Training was provided to the service delivery staff at each site (This training was carried out at all sites delivering MCH services, rather than just at OFC target sites, as a service to the MCH Division and to the Health Offices The OFC governorates will serve as an important pilot test of the system) Unfortunately, JSI/OFC does not have the staff or transportation resources to provide follow-up at all of these sites, but the OFC sites will receive continuing assistance in using and trouble-shooting the system A protocol for assessing the quality of data collection developed by the Management Advisor is being used by OFC staff, and the protocol will be made available for use by all MOPH staff Health Offices will also receive assistance in the use of the data generated for monitoring and decision-making

e Clinical equipment procurement

An important aspect of OFC efforts to improve MCH/FP service quality will be the provision of new equipment to complement that already in the sites Major procurements are always complex and time-consuming, more so to assure compliance with U S government procurement regulations This set of purchases -- totaling more than $400,000 -- is no exception Preparation of bidding documents and advertising of the specifications was completed by December 1996 JSI will review bids in January 1997, and delivery of the equipment to Yemen is expected in March or April, 1997

f Renovation of Health Centers

Although priority has been given to the renovation of those centers which will serve as training sites (see discussion under Lower Level Result 1 above), planning has also proceeded for the renovation of the other service delivery sites Assessment of the renovation needs of a number of these sites, including all of those in Hadramaut, were completed during this period Preparation for all remaining renovation work, including the development of detailed specifications, will be concluded during the next reporting period, so that work on these Health Centers can begin immediately upon completion of the training centers

g Training of doctors in the management of acute respiratory infections (ARI)

During the last quarter of 1996, the JSI/OFC Clinical Advisor conducted training of doctors in the management of ARI These infections are an important source of morbidity and mortality among children under five (see 1991/1992 Demographic and Health Survey for details) This training, involving groups of 12-15 doctors from each governorate, was conducted in collaboration with UNICEF

h Development of clinical and management protocols

The JSI/OFC Clinical Advisor and Management Advisor are developing clinical and management protocols/standards for use at OFC target sites These protocols will, of course, be useful at all service delivery sites after testing and refinement Clinical protocols were drafted during 1996 in the areas of infection prevention and acute respiratory infections A management protocols was drafted to assess the quality of HMIS data collection

i Technical assistance/monitoring visits

JSI/OFC staff travel frequently to all target sites for a variety of reasons related to contract implementation Whenever possible, advantage is taken during these visits to provide additional technical assistance The senior

advisors and the locally-recruited technical staff possess a variety of skills that can be brought to bear on service delivery and administrative problems encountered at the sites, and care is taken not to waste opportunities An especially important aspect of these visits is that they are nearly always undertaken with Health Office personnel Because of budgetary, transportation, and human resource limitations, independent site visits by Health Office staff are alarmingly rare While JSI/OFC constantly stresses the importance of regular supervision and seeks to help Health Office staff find long-term solutions to poor supervision, we recognize that these solutions are difficult and take time to solve Meanwhile, therefore, JSI/OFC provides frequent opportunities for these staff to visit sites, to participate fully in contract activities, and to accomplish supervisory work that might otherwise be lacking

J Improvements in the utilization of MCH services

The data collected for 1996 on the JSI/OFC contract "clinical" indicators (see Section 4 of this report) provides evidence that the number of clients receiving MCH services in many health centers has declined as compared with 1995 This is supported by anecdotal evidence from center directors and staff, and is also consistent with reports from the MOPH and from other donors that the volume of services has declined throughout the country The explanation most often put forward for this is that the economic situation prevents many poorer clients from seeking services because of lack of transportation or lack of funds to purchase services or drugs If indeed these macro- and microeconomic issues are controlling the level of service provision, then there may be little that a project like OFC can do to improve the situation However, efforts to increase the quality and utilization of services will clearly be the major emphasis for the remainder of the project This will include redoubled technical assistance to health center staff to improve clinical practices and the management of those practices, special training in priority clinical areas as delineated in the contract workplan, and continued intensive work with communities to enhance the sense of ownership of the health centers and thereby increase visibility and use

In addition, the presence of the midwifery trainers in the decentralized training centers should result in substantially greater use of those centers and their services The combination of OFC project inputs should therefore serve to improve service delivery as reflected by the contract indicators and more generally by increases in service utilization

Lower Level Result 3 "Community and individual participation increased in three governorates"

Increased community and individual participation and support for health services represents the best hope for sustained improvements in health status Achievement of this result will mean the demonstration of a model whereby communities assume greater ownership and control over the health care system, thus relieving the government of some of a burden that it cannot effectively bear

a Development of Community Partnership Agreements (CPA)

What may become the most important feature of OFC assistance in Yemen is the development and implementation of the Community Partnership concept Formal, written agreements are prepared and signed by those parties providing support to a Health Center the MOPH (with inputs from the central Ministry, the governorate Health Office, and the Health Manpower Institute), the Health Center itself, the community in which the center is located, and JSI/OFC The contributions of each party are spelled out and agreed to, and a community board is formed to manage the community's inputs and some of the inputs of the other parties JSI/OFC, always in collaboration with the Health Office, has been holding meetings with community representatives to introduce this concept, to explain its benefits, and define the various parties contributions It has been made explicit that OFC support to a Health Center is contingent upon support from the other parties

The response of communities to this concept has been overwhelmingly positive While the ability and willingness of communities to commit money and other resources varies, every community has agreed to provide at least the minimum level of support necessary to justify OFC support The Health Offices and the MOPH more generally have also been enthusiastic in their support

Because of the time-sensitive nature of activities at the training centers, JSI gave priority in 1996 to finalizing CPAs in those communities By the end of 1996, all of the communities in which training centers are located agreed to provide at least the minimum level of support required for JSI to proceed with preparation of the training site This minimum level of support consists of identification by the community of appropriate candidates for community midwife or primary health care worker training, assistance in obtaining written guarantees from accepted candidates' families that the candidate will complete training and work afterward, provision of furnished living accommodations for

trainers and trainees, and contributions to the living expenses of the trainees

The process of finalizing and signing these agreements has proven to be more labor-intensive and time-consuming than had been anticipated The target for the CPA performance indicator (#3 1) was 22 for 1996 While substantial progress was made toward finalizing many of these agreements in 1996, none were fully signed by all parties by the end of the year However, a variety of community meetings are scheduled for January and February at which all agreements for training center communities will be signed The additional time consumed in finalizing the inputs of all parties -- JSI/OFC, MOPH and Health Offices, HMIs, Health Centers, and communities -- should result in agreements that will form a strong, durable basis for health center improvement

b Community meetings and board formation

The processes for identifying and gaining support of key community members are complex and vary from place to place JSI/OFC governorate staff and their Health Office and Health Office colleagues have spent enormous time and energy assuring that mobilizing community support does not run afoul of political and social considerations Inevitably, some mistakes and false starts have been made, but these have uniformly been rectified -- a testimony both to the skills of the staff and to the goodwill of the communities

Meetings in both training site and non-training site communities were held during 1996 to introduce the OFC project and the concept of the community partnership, and frequent follow-up meetings were held to assure that momentum was not lost Community leaders were requested to form health committees that would take responsibility for community inputs to the partnerships The inputs of all parties were then negotiated

Because of variations in the communities and the individuals involved in developing the CPAs, somewhat different models for CPAs have evolved in the three governorates Although these differences tend to be more process-oriented than substantive, they do provide a "natural experiment" in the development of community participation JSI will carefully watch for any variations in outcome that might occur, and document them accordingly

c Other community contributions

Another positive outcome of the process of bringing together community members and Health Center staff has been immediate community contribution to some Health Center needs For example, a community meeting in Al Qutai led to a local businessman providing materials and labor to repair the center's water supply A meeting in Shagadirah led to the community constructing a small building to house the center's generator

Community meetings have also demonstrated the extent to which many communities have been supporting health activities for some time Hadramaut in particular has enjoyed active cooperation between health centers and their communities, with numerous examples of communities providing new construction and renovation Gaining this knowledge has allowed JSI/OFC to frame new community contributions as building upon past support

On a less positive note, the community meetings have also revealed substantial mistrust of government- and donor-sponsored projects Many community members are openly and frankly skeptical of whether the MOPH will deliver on its part of the commitments, and relate stories of donor representatives passing through with promises that are never delivered upon There are also some unhappy memories of past efforts by the government to channel assistance and cooperation through Local Councils, which were often perceived as being corrupt This is one of the real advantages of preparing written CPAs, which lends transparency to the process

d Support for District Health System

The MOPH has adopted the policy of promoting the District Health System (DHS) model developed by WHO, and, during this reporting period, began to request donor assistance in its implementation While this model goes well beyond the scope of a project like OFC in promoting multi-level health services in each District, the strategies promoted by OFC are entirely consistent with the model In particular, the model's emphasis on decentralization of funding and management are consistent with OFC's efforts to stimulate community participation Thus, OFC is assisting the MOPH in implementing the DHS in a number of small but important ways

- In response to a special request by the MOPH, JSI/OFC provided support for a workshop in Lahj governorate to introduce and plan for the DHS

- There is special interest in implementing the DHS in Hodeidah Governorate During 1996, the Community Participation Advisor and governorate staff facilitated the introduction of the DHS concepts in the Al Dhahi District during community meetings, and assisted Health Office staff in collecting data on the district which will be used in planning for DHS implementation

e Planning for more effective user fee systems

Contract activities in this area in 1996 consisted primarily of collecting information on the fee systems utilized in OFC-supported health centers, as well as on operating budgets The fee systems utilized vary widely, so the initial task in improving them is to obtain general agreement and official

sanction for the basic elements of a user fee system

The MOPH announced late in 1996 its intention to form a special committee to issue recommendations on cost recovery and cost sharing Both the JSI/OFC Management Advisor and Chief of Party will participate on this committee, which may provide the impetus for adoption of a standardized fee system Whether or not this committee is successful in having recommendations adopted, JSI/OFC will provide specific technical assistance to health centers in improving their fee systems in particular, and their internal financial management in general

4 Other activities not related to the Lower Level Results

This section describes a number of significant activities which are not directly related to a particular Lower Level Result, as well as some activities which were necessary to complete committments made prior to the amendment of the contract

a Staffing change

- Dr Yvonne Sidhom, Training and Hadramaut Resident Advisor, resigned for personal reasons in October 1996 After intensive discussions among JSI, USAID, and the MOPH, Dr Salem Ghanem was hired as the replacement This change also resulted in a change in the job description for the Hadramaut Advisor and a new plan for the management of training activities
- Dr Mahmoud Farag, Senior Population Policy Advisor, left Yemen in September 1996 upon the completion of his contract and completion of OFC support to the National Population Council

b Assistance to the National Population Council (NPC)

JSI/OFC's assistance to the NPC included the provision of technical assistance by a Senior Population Policy Advisor, whose activities were designed to form a bridge between policy development and service delivery concerns Highlights of the Policy Advisor's activities during 1996 included

- Conducting a variety of population-related awareness-raising activities, such as governorate-level seminars on population issues and planning for the Second National Population Policy Conference
- Redefining of objectives and targets of the National Population Policy in light of the findings of the 1991/1992 DHS and the 1994 census Recommendations were made to adopt more realistic targets, such as lowering goals for contraceptive prevalence
- Assisting the NPC in designing a National MCH/FP Program with important recommendations for improving MCH/FP service delivery This Program, which would in principle give higher profile to MCH, family planning, and population issues, has been officially adopted by the NPC with support from the MOPH It remains to be seen, however, what the operational mechanisms for such a program might be
- Assisting in the preparation of a RAPID presentation for use at the National Population Policy Conference

Additional assistance was also provided during 1996 in the planning and implementation of the Second National Population Conference With

assistance from the Futures Group under subcontract to JSI, OFC funded the preparation and delivery of a RAPID presentation at the Conference in October This assistance included the provision of computer and projection equipment, as well as support for the printing of the Conference proceedings

c Assistance in the implementation of National Immunization Days for polio irradication

The MOPH, with assistance from a variety of donor agencies, planned and executed on very short notice a nationwide campaign for polio irradication in November and December JSI/OFC provided support in the form of use of some project vehicles and field assistance by governorate staff

d Assistance in USAID closeout activities

The rapidity with which USAID staff were required to plan and execute the closure of the USAID/Yemen Mission created enormous difficulties JSI agreed to assist by assuming responsibility for the final disposal of some USAID property, and by providing some management support for USAID staff who are to remain at the U S Embassy

3b Current buy-ins

Not applicable to this contract

3c Current subcontracting activities

a Association for Voluntary and Safe Contraception International provides the MCH/Clinical Advisor (Dr Nagiba Abdulghany) and related consultants

b International Health and Development Associates provides the Training Advisor (Dr Yvonne Sidhom followed by Dr Salem Ghanem), and related consultants

c Program for Appropriate Technology in Health provides the Community Participation Advisor (Ms Sandra Loli) and related consultants

d The Futures Group provides the technical expertise and computer software to prepare RAPID presentations for Yemen

4 Performance

Following are the performance indicators applicable to the revised JSI/OFC contract Data are presented in tabular form, and as graphs for selected indicators in Appendix 1

Special Objective "Improved quality and use of integrated MCH/FP services in 22 Health Centers in three governorates"

Indicator 1 "Percentage of eligible children under one completing DPT/polio series at 22 Health Centers"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
13 60% (8,053 immunizations)	4 14% (2,535 immunizations)	14 73% (9,018 immunizations)	17 50%

Indicator 2 "Number of antenatal visits per pregnant woman at 22 Health Centers"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
Hadramaut 3 65 Hajjah 1 85 Hodeidah 2 13	Hadramaut 3 67 Hajjah 2 44 Hodeidah 2 80	Hadramaut 3 52 Hajjah 2 30 Hodeidah 2 12	Hadramaut 4 00 Hajjah 3 00 Hodeidah 3 00

Indicator 3 "Couple-years of protection (CYP) generated at 22 Health Centers"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
4,186	1,610	4,990	5,442

Intermediate Result "'Health Center Improvement' model in 22 Health Centers in three governorates established and documented"

Indicator 1 "Number of Health Centers implementing the model that have sustainable female staffing, minimum quality standards, and communities participating"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
0	0	0	12

Indicator 2 "Detailed report/evaluation of the model prepared and distributed to MOPH and donor community"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
0	0	0	1

Lower Level Result 1 "Sustainable female staffing established in centers in three governorates"

Indicator 1 1 "Number of decentralized training centers operating"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
0	0	0	9

Indicator 1 2 "Number of trainees nominated by communities which will contribute to their support"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1996 Target
0	NA	699	400

Indicator 1 3 "Number of trained female providers in place at 22 Health Centers"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
63	0	93*	132

*This increase of thirty providers from 1995-1996 is due primarily to the addition of FPHCWs in Hajjah Governorate who were trained by OXFAM, as well as normal staffing fluctuations in other centers JSI/OFC continues to anticipate a two-fold increase in providers as a result of contract efforts alone

Lower Level Result 2 "Minimum quality standards for centers in place in four governorates"

Indicator 2 1 "Number of centers passing inspection for minimum quality of facility and equipment"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
0	0	0	28

Indicator 2 2 "Number of Health Centers following minimum clinical and management protocols"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
0	0	0	20

Indicator 2 3 "Average number of months that ORS is out of stock at 22 HCs"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
3 36	NA	1 32	1 00

Indicator 2 4 "Average number of months that iron folate is out of stock at 22 HCs"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
6 80	NA	8 95	2 00

Indicator 2 5 "Average number of months that oral contraceptives are out of stock at 22 HCs"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
1 39	NA	33	50

Lower Level Result 3 Community and individual participation increased in three governorates"

Indicator 3 1 "Number of Community Participation Agreements signed and operational"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1996-8 Target
0	0	0	22

Indicator 3 2 "Number of Health Centers adopting and implementing more effective user fee systems"

1995 Baseline	4th Qtr 1996 Data	Annual 1996 Data	1998 Target
0	0	0	22

B. Administrative Information:

Financial Data

1 Total estimated cost $6,695,462
2 Expenditures (January 10, 1995 to December 31, 1996) $2,473,793
3 Remaining unexpended balance $4,221,669

Appendix 1

List of graphs

Comparative data by governorate

Comparative data by health center Hadramaut Governorate

Comparative data by health center Hajjah Governorate

Comparative data by health center Hodeidah Governorate

Appendix 2

Annual Inventory Report

Appendix 3

Annual Summary Training Report*

Type of Training	Date of Training	Number of participants trained			
		Hadramaut	Hajjah	Hodeidah	Lahj
Training of Trainers Creation of Governorate Refresher Training Teams	June '96	4	4	5	4
Infection Prevention Training at OFC Target Health Centers	August '96	All MCH staff	All MCH staff	All MCH staff	All MCH staff
Training of Physicians in ARI Management	Nov - Dec '96	13	15	20	15
Training of Trainers in HMIS	July '96	5	6	5	7
Training for all Governorate MCH center staff in HMIS	Aug - Sept '96	All MCH staff	All MCH staff	All MCH staff	All MCH staff
Refresher Training for Governorate MCH staff, conducted by Governorate Training Teams	Oct - Dec '96	45	46	60	45
Training of Trainers for Community Midwife Training Program	Dec '96 - Mar '97	5	8	6	0

*Detailed lists of trainees by name, gender, level of training, etc are available in JSI/OFC training files

JSI/OFC CONTRACT

Monitoring and Evaluation Plan

This is the OFC contract Monitoring and Evaluation Plan which will serve three purposes

1 To evaluate performance against the indicators established in contract amendment number 2

2 To track OFC's progress on a quarterly basis toward achieving those indicators

3 To track activities associated with, and which will contribute to, achieving those indicators For example, while in-service training is not itself a contract indicator, it is an activity which will contribute to increased quality standards in Health Centers (Lower Level result 2 and its indicators)

This Monitoring and Evaluation Plan, required by contract amendment 2, will allow OFC to identify and resolve problems which might otherwise hinder achieving our goals

The plan will use a number of instruments and methods to track progress on a quarterly basis This information will be reported to USAID on a quarterly and annual basis as part of the quarterly and annual reporting process Data will be collected in the following areas

1 Performance indicators for each targeted health center, and combined performance indicator data by governorate and for the contract as a whole
2 Status of training activities for Community Midwives and FPHCWs
3 Status of other training activities (e g clinical training, management training)
4 Status of renovation activities
5 Status of equipment/material procurement and distribution
6 Host country contributions

Governorate resident advisors are principally responsible for the collection of data However, the process also involves the efforts of other governorate OFC staff, Health Office staff, and Health Center staff At the Health Center level, data are collected utilizing the existing MOPH statistical forms and registers This information is collected and collated by OFC governorate staff in machine-readable form The data is then transmitted to the OFC office in Sana'a and entered into a database containing all performance indicator data

I Monitoring Methods

The following outlines the five major types of monitoring with associated methods and approaches

1 Data Collection

Special Objective Indicators
Intermediate Result Indicators
Lower Level Result Indicators

2 Reporting

Site visits/trip reports*, minutes of meetings, activities
Consultant Reports
Health Center records and reports
Quarterly Contract
Annual Contract

*(The responsibility for documenting site visits for supervisory and technical assistance purposes rests with JSI/OFC staff These visits, however, are undertaken in collaboration with MOPH colleagues whenever possible)

3 Financial Reporting and Monitoring

Monthly Financial Reports
Monthly Invoices
Contract Budget Tracking

4 Annual Review

Annual Reports and Performance Indicators
Subjective evaluations of contract progress/problems by staff and counterparts

5 Final Evaluation

II Indicators and Activities monitoring

1 **Special Objective** Improved quality and use of Integrated MCH/FP services in 22 Health centers in three governorate

Contributing Activities

1 Procurement of Equipment
Method of Monitoring Procurement Status Report, site visits
Information/Data Monitored monitor procurement process including needs identified, determine specifications, advertise, bidding,

purchasing, shipping, customs clearance, delivery to health centers
Frequency quarterly

2 Upgrade/renovate Health Centers
Method of Monitoring Renovation Status Report, inspection and acceptance reports, invoicing
Information/Data Monitored monitor progress of renovations including needs identification, establishing minimum standards, engineering assessment and design, competitive bidding process, contract and supervise renovations, inspection and acceptance
Frequency quarterly and periodically

3 Clinical Standards and Protocols
Method of Monitoring Supervisor visit reports, checklists, quarterly reports
Information/Data Monitored Establish and monitor infection prevention, family planning services, antenatal care, diarrheal disease care, immunizations, recording keeping Provision of technical assistance and problem solving
Frequency Quarterly, periodic supervision

4 Management
Method of Monitoring Health center records, quarterly reports
Information/Data Monitored vaccination records
Frequency monthly, quarterly

SO Indicator 1 Percentage of eligible children under one completing DPT/polio series at 22 Health Centers

Method of Monitoring Monthly Health center records, quarterly reports
Information/Data Monitored Immunization records
Frequency quarterly

SO Indicator 2 Number of Antenatal visits per pregnant woman at 22 Health Centers

Method of Monitoring health center records, quarterly reports,
Information/Data Monitored Number of antenatal visits
Frequency quarterly

SO Indicator 3 Couple Years of Protections (CYP) generated at 22 Health Centers

Method of Monitoring health center records, inventory, quarterly reports
Information/Data Monitored contraceptives distributed
Frequency quarterly

Intermediate Result Health Center Improvement Model in 22 health Centers in three governorates established and documented

Method of Monitoring quarterly reports, site visits, supervisor visits, health center records, evaluation
Information/Data Monitored contract indicators, lessons learned
Frequency quarterly indicators, final report

IR Indicator 1 Number of HCs implementing the model that have sustainable female staffing, quality standards, and communities participating

1 Procurement of Equipment

Method of Monitoring Procurement Status Report, site visits
Information/Data Monitored monitor procurement process including needs identified, determine specifications, advertise, bidding, purchasing, shipping, customs clearance, delivery to health centers
Frequency quarterly

2 Clinical Standards and Protocols

Method of Monitoring Supervisor visit reports, checklists, quarterly reports
Information/Data Monitored Establish and monitor infection prevention, family planning services, antenatal care, diarrheal disease care, immunizations, recording keeping Provision of technical assistance and problem solving
Frequency quarterly, final report

3 Training

Preservice- TOT and Community Midwife training

In service training- refresher training, clinical training, supervisory and management training, equipment o & m, community health committees

Method of Monitoring training reports, trainee evaluation reports
Information/Data Monitored dates, locations, number of trainees, skills demonstrated, number of trainees graduating, number of trainees working in area of training, cost per trainee
Frequency quarterly, final report

IR Indicator 2 Report/evaluation of model prepared and distributed to MOPH and donor community

Method of Monitoring Report
Information/Data Monitored progress toward indicators, achievements, problems, recommendations
Frequency End-of-project summary report

Lower Level Result 1 Sustained female staffing established in Health Centers in three governorates

Method of Monitoring Field visits
Information/Data Monitored Increase in number of female staff, operation of training centers, community support for training and service delivery
Frequency Quarterly, final report

LLR Indicator 1 1 Number of Decentralized Training Centers Operating

Method of Monitoring quarterly reports, training reports, supervisor visits
Information/Data Monitored dates, locations, number of trainees, skills demonstrated, number of trainees graduating, number of trainees working in area of training, cost per trainee
Frequency quarterly reports, periodic supervisor reports

LLR Indicator 1 2 Number of Trainees nominated by communities which will contribute to their support

Method of Monitoring training status reports
Information/Data Monitored number
Frequency quarterly

Contributing Activity Community Participation

Method of Monitoring meeting minutes, field trip reports, community partnership agreements
Information/Data Monitored number of trainees supported by communities, amount of support
Frequency quarterly

LLR Indicator 1 3 Number of trained female providers in place in 22 Health Centers

Method of Monitoring training reports, supervisory visits, quarterly reports
Information/Data Monitored number of female health care providers by center
Frequency quarterly

Contributing Activities

1 Preservice Training - Community Midwife training, and TOT

Method of Monitoring training reports, trainee evaluation reports
Information/Data Monitored dates, locations, number of trainees, skills demonstrated, number of trainees graduating, number of trainees working in area of training, cost per trainee
Frequency for each training course

2 Community Health Committee

Method of Monitoring community agreements, and meetings
Information/Data Monitored number of trainees supported by communities
Frequency quarterly reports

Lower Level Result 2 Minimum quality standards for HCs in place in four governorates

Method of Monitoring supervisor visit reports, quarterly reports
Information/Data Monitored supervisor checklist information
Frequency periodic supervisor reports, quarterly reports

LLR Indicator 2 1 Number of centers passing inspection for minimum quality of facilities and equipment

Method of Monitoring renovation status reports, procurement status reports, supervisor checklists and visits, quarterly reports
Information/Data Monitored centers with minimum quality standards
Frequency quarterly reports, periodic supervisor checklists

LLR Indicator 2 2 Number of HCs following minimum clinical and management protocols

Method of Monitoring supervisor visits, reports, checklists, and quarterly reports
Information/Data Monitored management and clinical protocol standards-Establish and monitor infection prevention, family planning services, antenatal care, diarrheal disease care, immunizations, recording keeping Provision of technical assistance and problem solving

Frequency periodic, and quarterly reports

Contributing Activity

In service Training - Refresher training, Clinical Training, Supervisor and Management Training

Method of Monitoring training reports, trainee evaluation reports
Information/Data Monitored dates, locations, number of trainees, skills demonstrated, number of trainees graduating, number of trainees working in area of training, cost per trainee
Frequency for each training course

LLR indicator 2 3 Average number of months that ORS is out of stock

Method of Monitoring Health Center Records
Information/Data Monitored inventory levels
Frequency quarterly

LLR Indicator 2 4 Average number of months that iron folate is out of stock at 22 HCS

Method of Monitoring Health Center records
Information/Data Monitored inventory levels
Frequency quarterly

LLR Indicator 2 5 Average number of months that oral contraceptives are out of stock at 22 HCs

Method of Monitoring Health Center records
Information/Data Monitored inventory levels
Frequency quarterly

Lower Level Result 3 Community and Individual participation increased in three governorates

Method of Monitoring meeting minutes, site visit reports, community participation agreements, quarterly reports
Information/Data Monitored community participation agreements, community contributions, number of meetings and results, community health committee, Health Office/Community Support Plans, Support to trainees and graduates, user fees
Frequency Monthly and quarterly

LLR Indicator 3 1 Number of Community Participation Agreements signed and operational

Method of Monitoring OFC files, quarterly reports
Information/Data Monitored presence of signed agreements and amount of community contribution
Frequency quarterly

Contributing Activities

1 Community Health Committee

Method of Monitoring files, minutes of meetings, reports
Information/Data Monitored Existence of a committee meeting regularly with structure, policy, and involvement in health center delivery Types of activities, management and oversight, budget
Frequency quarterly

2 Host Country Contributions

Method of Monitoring Host country contribution reports
Information/Data Monitored MOPH, HO, and community human resources, facilities, travel costs, training and representational costs
Frequency quarterly

LLR Indicator 3 2 Number of HCs adopting and implementing more effective user fee systems

Method of Monitoring health center records, supervisory and technical assistance visits and reports
Information/Data Monitored policies, collection and accounting system, level of contributions
Frequency periodic and quarterly

Contributing Activities

1 Training - Supervisory and Management Training, Formal and Informal Community Participation/Committee training

Method of Monitoring training reports, trainee evaluation reports
Information/Data Monitored dates, locations, number of trainees, skills demonstrated, number of trainees graduating, number of trainees working in area of training, cost per trainee
Frequency for each training course

2 Community Participation

Community Health Committee
Method of Monitoring files, minutes of meetings, reports
Information/Data Monitored Existence of a committee meeting regularly with structure, policy, and involvement in health center delivery Types of activities, management and oversight, budget
Frequency quarterly

3 Management

Method of Monitoring HO, HC and Community meetings, systems agreed to, systems in use, budgeting and financial management, Supervisory reports, quarterly reports

Information/Data Monitored Assistance to MOPH and HO, MOPH supervision,
Assistance to HMI in improving training and supervision
Center and/or MCH/FP management procedures (personnel, administrative, financial, Health MIS, Inventory system, Record keeping system
Frequency quarterly

III Host Country Contributions

Method of Monitoring host country contribution report
Information/Data Monitored MOPH, HO and community humanresources, Travell Costs (community and MOPH), Facilities (community and MOPH), Training support costs (community and MOPH), Representational costs
Frequency Quarterly

IV Inventories

Method of monitoring OFC records, annual inventory report
Information/Data Monitored Standardinformationn as required by USAID policies and procedures
Frequency regular updating of records, annually

V Budget and Finance

Method of Monitoring Monthly financial reports and invoices
Information/data Monitored monthly expensess and cumulativee expenses, by line item Variance from contract budget
Frequency Monthly

OFC CONTRACT
TRAINING PLAN 1997-1998

TYPE OF TRAINING	CATEGORY OF TRAINEE	COLLABORATING INSTITUTIONS	LOCATION	ESTIMATED TIMING/ DURATION
Training of Trainers for Community Midwife Training Program	Midwife Trainer/Supervisors	MOPH, HMI PRIME/INTRAH	SANA'A HMI	Dec '96 - Mar '97 (3 Months)
Decentralized training of Community Midwives (See list of sites and trainers attached)	Secondary school graduates meeting selection criteria	MOPH, HMIs, Health Offices, Health Centers, Community Boards	Branch HMIs and decentralized training centers	Apr '97 - Aug '98 (18 months)
Management Workshop for Senior Staff	Governorate Director-Generals, Deputies, Public Health Directors	MOPH, NPC	Sana'a	May - June '97 (2 weeks)
Training in family planning counselling (to be followed by on-the-job training and TA)	Health Center staff	--	Health Centers	May - June '97 (2 days)
Training for physicians in management of CDD	Physicians at target health centers and in Health Offices	UNICEF	Governorate capitals	July - Aug '97 (4 days)
Training for health center staff in emergency obstetric care (to be followed by on-the-job training and TA)	Staff of target health centers	MOPH, appropriate staff from Governorate referral hospitals	Health Centers	Sep - Oct '97 (2 days)
Quality of care workshop	Health Center Directors	MOPH	Sana'a	Jan '98 (2 days)

OFC TRAINING PLAN
P 2

Training in IUD insertion	Qualified Health Center staff	YFCA?	Sana'a, Taiz?, Dhamar?	Feb '98 (multiple sessions -- 2 weeks each)
Training in improved user fee system	Health Center Directors	MOPH, UPHCP?	Governorate capitals	Oct - Nov '97 (3-4 days)
Management and/or Strategic Planning and/or Leadership training for senior staff	Governorate Director Generals, Central MOPH Senior Staff	Appropriate internationally recognized training organization	Regional site, e g , Cairo, Amman	TBD (1-2 weeks)
Ad hoc "refresher courses" for Community Midwife trainers	CM Trainer/Supervisors	MOPH, HMI	Governorate Capitals or training sites	TBD (based on supervision visit recommendations), Brief duration (2-3 days)
Refresher training for Health Center staff	MCH staff	Governorate Health Office Training Teams	Governorate capitals	TBD (1 week)
Ongoing, on-the-job training and technical assistance for Health Centers in clinical and management issues	Health Center MCH staff, Health Center Directors	Health Office staff	Target Health Centers	Life of project (1-3 days)